

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30827

State File No.

FILED SEP 29, 1947

Registration District No.

Primary Registration District No. 2-0-18

Registrar's No. 65

1. PLACE OF DEATH:

(a) County DeWitt
(b) City or town Salem, Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: RT 2, Salem, Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Peggy Marie Farrar

3. (b) If veteran, name war. - 3. (c) Social Security No. -

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive - years
7. Birth date of deceased Aug 21 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 hr. min.

9. Birthplace Salem Rural, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Baby

11. Industry or business -

12. Name Homer Edwin Farrar 0

13. Birthplace Salem, Mo
(City, town, or county) (State or foreign country)

14. Maiden name Grace May Callahan 0

15. Birthplace Salem, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Homer Edwin Farrar

(b) Address Salem, Mo

17. (a) Burial (b) Date thereof Aug 24 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem, Mo

18. (a) Signature of funeral director -

(b) Address -

19. (a) 9-13-47 (b) M. H. Hart, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County DeWitt 33
(c) City or town Rural - Salem
(If outside city or town limits, write "RURAL")
(d) Street No. Rt. 2 - Salem, Mo
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23
year 1947 hour 8 minutes 0 P.M.

21. I hereby certify that I attended the deceased from None
19 - to 19 -
that I last saw h. - alive on -
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration -

Due to -

Due to -

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None 159 69

Of operations None 159 69
Of autopsy None 159 69

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence -

(c) Where did injury occur? - (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home

While at work? - (Specify type of place) (e) Means of injury - 0

23. Signature R. B. Beers M.D. (M. D. or other)

Address -

Date signed 9-12-47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Net
Date Filed

RECEIVED

District Health Officer No. 5,

District File Number 947521

Date Filed: 9-25-47

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.